OKLAHOMA
State Department
of Health

Delivery via email to: pbehrens@covling.org

January 26, 2024

License Number: AL7264

Ms. Patricia Behrens, Administrator
Covenant Living Of Bixby
7300 East 121st Place South
Bixby, OK 74008

RE: Survey Event ID: ZD4B11

Dear Ms. Behrens:

On **January 3, 2024**, agents from our office concluded a State Licensure survey along with a complaint investigation at your facility. The deficiencies found during the survey are identified on the enclosed STATE FORM.

These deficiencies represented the potential for more than minimal harm. Your facility will be given an opportunity to correct deficiencies prior to assessing penalties, however, if upon revisit your facility has not corrected the deficiencies penalties will be applied starting on **January 3, 2024**.

Please note the items listed in the deficiency column of the STATE FORM. You have two choices of methods to prepare the written plan of correction (POC). The first method is to type the plan of correction and anticipated date of completion in the space provided on the right half of the STATE FORM. If additional space is needed, supplemental sheets may be attached.

The second method is to prepare your plan on the Optional Plan of Correction Template (attached). Use of the template is voluntary. It is intended to help you submit a complete and acceptable plan of correction. If you choose to use the optional template, complete one template for each deficiency cited on the STATE FORM. In the space provided on the right half of the STATE FORM, type a notation that the plan of correction is being submitted using the optional template. Copies of the form and instructions are available at: http://www.ok.gov/health. This link opens the OSDH home page. To find the optional POC, **click on Services**, then **click on Long Term Care.** The link to the forms can be found by selecting **Long Term Care Forms** on the left menu column.

To be found acceptable by the OSDH, the plan of correction must:

(1) Address how corrective action will be accomplished for affected residents;
(2) Address how other residents with the potential to be affected will be identified;
(3) Address measures or systemic changes to ensure the deficiency will not recur;
(4) Indicate how the center plans to monitor performance to ensure corrections are sustained;
(5) Include dates when corrective action and monitoring will be completed for each violation;
(6) Be signed by the administrator.

OKLAHOMA
State Department
of Health

Delivery via email to: PBehrens@covliving.org

March 18, 2024

License Number: AL7264

Ms. Patricia Behrens, Administrator
Covenant Living Of Bixby
7300 East 121st Place South
Bixby, OK 74008

RE: Survey Event ZD4B11

Dear Ms. Behrens:

On **January 3, 2024**, a Licensure inspection with a complaint survey was conducted at your Assisted Living Center facility. Deficiencies were identified and we have received your plan of correction for these deficiencies. Your plan of correction is acceptable.

This acceptance acknowledges that your facility has indicated a willingness and ability to make corrections adequately and timely. **Our acceptance does not absolve the facility's responsibility for compliance** should the implementation not result in correction and compliance.

You have alleged that the deficiencies cited on that survey have been corrected and you were in substantial compliance by **March 15, 2024**.

We will conduct a revisit at your facility to verify that all violations have been corrected. If you have any questions, please contact this office at (405) 426-8200.

Respectfully,

Tempal Killman

Tempal Killman, Enforcement Analyst
Long Term Care | Enforcement Division
Oklahoma State Department of Health

Enclosure

Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 2/23/2024** **Facility Name:** Covenant Living of Bixby **License Number:** AL7264 **Survey Event ID:** ZD4B11 **Date Survey Completed: 1/3/2024**

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C 921 SS=F	Based on: record review and interview the facility failed to a. have a registered nurse or pharmacist perform the residents' monthly medication review for four (#1, 2, 3, and #6) of four residents whose clinical records were reviewed for medication and administration; b. perform a quarterly medication review by a pharmacist for all residents in the facility.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Enter the assisted living center's opening comments or disclosure statement (Optional).

REQUIRED ELEMENTS OF A PLAN	ASSISTED LIVING CENTER'S PLAN ELEMENTS
1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?	A medication review was conducted for #1, 2, 3 and #6 on 1/18/2024.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	An audit of resident's charts was completed on 2/29/2024.
OSDH Response: Element accepted Yes ☐ No ☐	
3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?	The RN will complete the monthly medication reviews and report findings to the Administrator. The Pharmacy will conduct quarterly reviews and report their findings to the Administrator.
OSDH Response: Element accepted Yes ☐ No ☐	
4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include: a. How the correction will be evaluated for effectiveness; b. How the correction will be incorporated into the center's quality assurance system; and c. How monitoring records will be kept to evidence the correction.	The RN will report the results of the monthly medication reviews and the quarterly pharmacy reviews to the QAPI committee. We will evaluate our correction for effectiveness by ensuring that during the quality assurance meetings the dates of the most recent medication reviews are recorded. Any reviews completed after the quality assurance meeting will be confirmed during the next quality assurance meeting. We will incorporate our correction into our quality assurance system by addressing the RN monthly medication reviews and the quarterly pharmacy reviews under the compliance section of our quality assurance meetings. Evidence of the correction will be maintained in the quality assurance committee meeting minutes.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	3/15/2024
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature Patricia Behrens OAC 310:663-25-4(F)			**Date 3/7/2024**
If this sheet amends or adds information to a Plan of Correction previously submitted, indicate the date of the addendum and by whom it is submitted.			
Addendum Date	Enter a date of addendum.	**Submitted by**	Enter name of person submitting addendum.
Items Below Are For OSDH Use Only			
Plan of Correction: ☐ Acceptable ☐ Unacceptable Date: Click here to enter a date. Surveyor: Surveyor			
If Plan of Correction is unacceptable, the reasons are as follows: Click here to enter text. Facility in Compliance by: Click here to enter a date.			

Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 2/23/2024** **Facility Name:** Covenant Living of Bixby **License Number:** AL7264 **Survey Event ID:** ZD4B11 **Date Survey Completed: 1/3/2024**

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C 1912 SS=E	Based on: record review and interview, the facility failed to prepare a written incident report for one (#9) of one resident with a documented allegation of abuse, an allegation of neglect for one (#4), and allegations of neglect for an unknown number of residents.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Investigations into the allegations of abuse and neglect were conducted. The allegations were unsubstantiated.

REQUIRED ELEMENTS OF A PLAN	ASSISTED LIVING CENTER'S PLAN ELEMENTS
1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?	The staff has been trained in abuse reporting protocols. The nursing staff has been in-serviced on the standards of practice for medication administration and ensuring the residents take all their medications.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	An audit of residents was conducted on 2/27/24 and no deficient practice was found.
OSDH Response: Element accepted Yes ☐ No ☐	
3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?	Staff were re-educated on the Reporting process from 1/10/24 – 1/25/24. (Exhibit 5) Allegations are to be reported to the ED. On 2/28/24 the staff was in-serviced on Abuse and Neglect. (Exhibit 6) During daily (business days) stand up meeting, incident reports will be reviewed, and the ED will report to the state agency items that require reporting.
OSDH Response: Element accepted Yes ☐ No ☐	
4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include: a. How the correction will be evaluated for effectiveness; b. How the correction will be incorporated into the center's quality assurance system; and c. How monitoring records will be kept to evidence the correction.	The ED/designee will complete 5 audits week for a period of 12 weeks, these audits (Exhibit 7) will be asking staff who to report allegations to. During new staff orientation, the allegation reporting process will be reviewed. During the QAPI committee allegations that were reported to the state to ensure that the proper investigation was completed. The ED/designee will report the results of the audits and the committee will determine if more education is needed. Audits will be reported to the QAPI committee, and the committee will determine if more education with staff is needed. Evidence of the correction will be maintained in the quality assurance committee meeting minutes.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	3/15/2024

OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature **Patricia Behrens** OAC 310:663-25-4(F)			**Date 3/7/2024**
If this sheet amends or adds information to a Plan of Correction previously submitted, indicate the date of the addendum and by whom it is submitted.			
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Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 2/23/2024** **Facility Name:** Covenant Living of Bixby **License Number:** AL7264 **Survey Event ID:** ZD4B11 **Date Survey Completed: 1/3/2024**

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C 1921 SS=E	Based on: record review and interview, the facility failed to administer medications according to physician's orders for one (#2) of four sample residents whose clinical records were reviewed for medication administration.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Enter the assisted living center's opening comments or disclosure statement (Optional).

REQUIRED ELEMENTS OF A PLAN	ASSISTED LIVING CENTER'S PLAN ELEMENTS
1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?	The nursing staff was in-serviced on the 5 rights of medication administration on 3/6/24. (Exhibit 3) Any nursing staff members that were unable to attend will be in-serviced before their next shift. The nurse shall randomly oversee medication passes. (Exhibit 4) Current orders for residents will be sent to their physician monthly with a request to review for accuracy, inform us of any changes needed, sign and return. A copy of current physician orders and a physician visit note will be sent with residents when they go to doctor appointments. Returned physician orders and physician visit notes will be reviewed and addressed by the nurse.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	All new and existing residents will have their medications reviewed monthly.
OSDH Response: Element accepted Yes ☐ No ☐	
3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?	The nurse will review all returned physician orders and physician visit notes and address any changes received.
OSDH Response: Element accepted Yes ☐ No ☐	
4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include: a. How the correction will be evaluated for effectiveness; b. How the correction will be incorporated into the center's quality assurance system; and c. How monitoring records will be kept to evidence the correction.	We will ensure that our corrections are sustained by addressing monthly medication reviews, med errors and the results of random medication pass audit during our quality assurance meetings. We will evaluate our correction for effectiveness by discussing trends in medication error root causes. The correction will be incorporated into our quality assurance system by addressing monthly medication reviews and medication errors during our quality assurance meetings. Evidence of the correction will be maintained in the quality assurance committee meeting minutes.

OSDH Response: Element accepted Yes ☐ No ☐			
5. On what date will corrective action be completed?		3/15/2024	
OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature **Patricia Behrens** OAC 310:663-25-4(F)			**Date 3/7/2024**
If this sheet amends or adds information to a Plan of Correction previously submitted, indicate the date of the addendum and by whom it is submitted.			
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Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 2/23/2024** **Facility Name:** Covenant Living of Bixby **License Number:** AL7264 **Survey Event ID:** ZD4B11 **Date Survey Completed: 1/3/2024**

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C 1923 SS=D	Based on: record review and interview, the facility failed to accurately document the administration of medication for one (#6) of four sampled residents whose clinical records were reviewed for medication administration.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Enter the assisted living center's opening comments or disclosure statement (Optional).

REQUIRED ELEMENTS OF A PLAN	**ASSISTED LIVING CENTER'S PLAN ELEMENTS**
1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?	This resident is no longer at the facility.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	The pharmacy conducted a review on 1/18/24 and no deficient practices were found.
OSDH Response: Element accepted Yes ☐ No ☐	
3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?	The nursing staff will be in-serviced on the Standards of Practice of Medication Administration, MARs and reporting errors to the RN nurse manager/designee (Exhibit 1) on 3/7/24. Any nursing staff that were unable to attend will be in-serviced before their next shift. During daily (business days) stand up meetings the RN nurse manager or designee will review new orders for accuracy.
OSDH Response: Element accepted Yes ☐ No ☐	
4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include: a. How the correction will be evaluated for effectiveness; b. How the correction will be incorporated into the center's quality assurance system; and c. How monitoring records will be kept to evidence the correction.	The RN nurse manager/designee will review 5 MARS each week for a period of 12 weeks to ensure that the MAR matches the Physician's order and that medication is being administered correctly. Results of the audits (Exhibit 2) will be communicated to the QAPI committee. Audits will be reviewed by the QAPI committee. The results of the audits will be reported to the QAPI committee for a period of 12 weeks, the threshold for compliance will be 100%. Evidence of the correction will be maintained in the quality assurance committee meeting minutes.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	3/15/2024
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature **Patricia Behrens**	**Date 3/7/2024**

OAC 310:663-25-4(F)

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OKLAHOMA
State Department
of Health

Delivery via email to: PBehrens@covliving.org

April 24, 2024

License Number: AL7264

Ms. Patricia Behrens, Administrator
Covenant Living Of Bixby
7300 East 121st Place South
Bixby, OK 74008

RE: Survey Event ZD4B12

Dear Ms. Behrens:

On **April 23, 2024,** an off-site paper revisit was conducted for your facility by this agency. The findings of the revisit indicate that the deficiencies cited during your survey on **January 3, 2024,** have now been corrected effective **March 15, 2024.**

If you have any questions concerning the information in this letter, please contact the Enforcement worker at (405) 426-8200.

Respectfully,

Tempal Killman

Tempal Killman, Enforcement Analyst
Long Term Care | Enforcement Division
Oklahoma State Department of Health

Enclosure

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL7264	A. BUILDING: _____ B. WING _____	R-C 04/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COVENANT LIVING OF BIXBY	7300 EAST 121ST PLACE SOUTH BIXBY, OK 74008

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{C 000}	INITIAL COMMENTS On 04/23/24, an offsite/revisit was conducted. The deficiencies were cleared.	{C 000}		

Oklahoma State Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

OKLAHOMA
State Department
of Health

Delivery via email to: PBehrens@covliving.org

March 18, 2024

License Number: AL7264

Ms. Patricia Behrens, Administrator
Covenant Living Of Bixby
7300 East 121st Place South
Bixby, OK 74008

RE: Survey Event ZD4B11

Dear Ms. Behrens:

On **January 3, 2024**, a Licensure inspection with a complaint survey was conducted at your Assisted Living Center facility. Deficiencies were identified and we have received your plan of correction for these deficiencies. Your plan of correction is acceptable.

This acceptance acknowledges that your facility has indicated a willingness and ability to make corrections adequately and timely. **Our acceptance does not absolve the facility's responsibility for compliance** should the implementation not result in correction and compliance.

You have alleged that the deficiencies cited on that survey have been corrected and you were in substantial compliance by **March 15, 2024**.

We will conduct a revisit at your facility to verify that all violations have been corrected. If you have any questions, please contact this office at (405) 426-8200.

Respectfully,

Tempal Killman

Tempal Killman, Enforcement Analyst
Long Term Care | Enforcement Division
Oklahoma State Department of Health

Enclosure

Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 2/23/2024** **Facility Name:** Covenant Living of Bixby **License Number:** AL7264 **Survey Event ID:** ZD4B11 **Date Survey Completed: 1/3/2024**

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C 921 SS=F	Based on: record review and interview the facility failed to a. have a registered nurse or pharmacist perform the residents' monthly medication review for four (#1, 2, 3, and #6) of four residents whose clinical records were reviewed for medication and administration; b. perform a quarterly medication review by a pharmacist for all residents in the facility.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Enter the assisted living center's opening comments or disclosure statement (Optional).

REQUIRED ELEMENTS OF A PLAN	ASSISTED LIVING CENTER'S PLAN ELEMENTS
1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?	A medication review was conducted for #1, 2, 3 and #6 on 1/18/2024.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	An audit of resident's charts was completed on 2/29/2024.
OSDH Response: Element accepted Yes ☐ No ☐	
3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?	The RN will complete the monthly medication reviews and report findings to the Administrator. The Pharmacy will conduct quarterly reviews and report their findings to the Administrator.
OSDH Response: Element accepted Yes ☐ No ☐	
4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include: a. How the correction will be evaluated for effectiveness; b. How the correction will be incorporated into the center's quality assurance system; and c. How monitoring records will be kept to evidence the correction.	The RN will report the results of the monthly medication reviews and the quarterly pharmacy reviews to the QAPI committee. We will evaluate our correction for effectiveness by ensuring that during the quality assurance meetings the dates of the most recent medication reviews are recorded. Any reviews completed after the quality assurance meeting will be confirmed during the next quality assurance meeting. We will incorporate our correction into our quality assurance system by addressing the RN monthly medication reviews and the quarterly pharmacy reviews under the compliance section of our quality assurance meetings. Evidence of the correction will be maintained in the quality assurance committee meeting minutes.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	3/15/2024
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature Patricia Behrens OAC 310:663-25-4(F)			**Date 3/7/2024**
If this sheet amends or adds information to a Plan of Correction previously submitted, indicate the date of the addendum and by whom it is submitted.			
Addendum Date	Enter a date of addendum.	**Submitted by**	Enter name of person submitting addendum.
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Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 2/23/2024** **Facility Name:** Covenant Living of Bixby **License Number:** AL7264 **Survey Event ID:** ZD4B11 **Date Survey Completed: 1/3/2024**

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C 1912 SS=E	Based on: record review and interview, the facility failed to prepare a written incident report for one (#9) of one resident with a documented allegation of abuse, an allegation of neglect for one (#4), and allegations of neglect for an unknown number of residents.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Investigations into the allegations of abuse and neglect were conducted. The allegations were unsubstantiated.

REQUIRED ELEMENTS OF A PLAN	ASSISTED LIVING CENTER'S PLAN ELEMENTS
1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?	The staff has been trained in abuse reporting protocols. The nursing staff has been in-serviced on the standards of practice for medication administration and ensuring the residents take all their medications.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	An audit of residents was conducted on 2/27/24 and no deficient practice was found.
OSDH Response: Element accepted Yes ☐ No ☐	
3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?	Staff were re-educated on the Reporting process from 1/10/24 – 1/25/24. (Exhibit 5) Allegations are to be reported to the ED. On 2/28/24 the staff was in-serviced on Abuse and Neglect. (Exhibit 6) During daily (business days) stand up meeting, incident reports will be reviewed, and the ED will report to the state agency items that require reporting.
OSDH Response: Element accepted Yes ☐ No ☐	
4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include: a. How the correction will be evaluated for effectiveness; b. How the correction will be incorporated into the center's quality assurance system; and c. How monitoring records will be kept to evidence the correction.	The ED/designee will complete 5 audits week for a period of 12 weeks, these audits (Exhibit 7) will be asking staff who to report allegations to. During new staff orientation, the allegation reporting process will be reviewed. During the QAPI committee allegations that were reported to the state to ensure that the proper investigation was completed. The ED/designee will report the results of the audits and the committee will determine if more education is needed. Audits will be reported to the QAPI committee, and the committee will determine if more education with staff is needed. Evidence of the correction will be maintained in the quality assurance committee meeting minutes.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	3/15/2024

OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature **Patricia Behrens** OAC 310:663-25-4(F)			**Date 3/7/2024**
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Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 2/23/2024** **Facility Name:** Covenant Living of Bixby **License Number:** AL7264 **Survey Event ID:** ZD4B11 **Date Survey Completed: 1/3/2024**

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C 1921 SS=E	Based on: record review and interview, the facility failed to administer medications according to physician's orders for one (#2) of four sample residents whose clinical records were reviewed for medication administration.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Enter the assisted living center's opening comments or disclosure statement (Optional).

REQUIRED ELEMENTS OF A PLAN	ASSISTED LIVING CENTER'S PLAN ELEMENTS
1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?	The nursing staff was in-serviced on the 5 rights of medication administration on 3/6/24. (Exhibit 3) Any nursing staff members that were unable to attend will be in-serviced before their next shift. The nurse shall randomly oversee medication passes. (Exhibit 4) Current orders for residents will be sent to their physician monthly with a request to review for accuracy, inform us of any changes needed, sign and return. A copy of current physician orders and a physician visit note will be sent with residents when they go to doctor appointments. Returned physician orders and physician visit notes will be reviewed and addressed by the nurse.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	All new and existing residents will have their medications reviewed monthly.
OSDH Response: Element accepted Yes ☐ No ☐	
3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?	The nurse will review all returned physician orders and physician visit notes and address any changes received.
OSDH Response: Element accepted Yes ☐ No ☐	
4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include: a. How the correction will be evaluated for effectiveness; b. How the correction will be incorporated into the center's quality assurance system; and c. How monitoring records will be kept to evidence the correction.	We will ensure that our corrections are sustained by addressing monthly medication reviews, med errors and the results of random medication pass audit during our quality assurance meetings. We will evaluate our correction for effectiveness by discussing trends in medication error root causes. The correction will be incorporated into our quality assurance system by addressing monthly medication reviews and medication errors during our quality assurance meetings. Evidence of the correction will be maintained in the quality assurance committee meeting minutes.

OSDH Response: Element accepted Yes ☐ No ☐			
5. On what date will corrective action be completed?		3/15/2024	
OSDH Response: Element accepted Yes ☐ No ☐			
Administrator's Signature **Patricia Behrens** OAC 310:663-25-4(F)			**Date 3/7/2024**
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Oklahoma State Department of Health Creating a State of Health Protective Health Services Long Term Care Service	**OPTIONAL PLAN OF CORRECTION TEMPLATE** **Current Date: 2/23/2024** **Facility Name:** Covenant Living of Bixby **License Number:** AL7264 **Survey Event ID:** ZD4B11 **Date Survey Completed: 1/3/2024**

SUMMARY OF DEFICIENCY CITED BY OSDH

ID Prefix Tag: C 1923 SS=D	Based on: record review and interview, the facility failed to accurately document the administration of medication for one (#6) of four sampled residents whose clinical records were reviewed for medication administration.

ASSISTED LIVING CENTER'S PLAN OF CORRECTION

Assisted Living Center's Comments: Enter the assisted living center's opening comments or disclosure statement (Optional).

REQUIRED ELEMENTS OF A PLAN	**ASSISTED LIVING CENTER'S PLAN ELEMENTS**
1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?	This resident is no longer at the facility.
OSDH Response: Element accepted Yes ☐ No ☐	
2. How will other residents having the potential to be affected by the same deficient practice be identified?	The pharmacy conducted a review on 1/18/24 and no deficient practices were found.
OSDH Response: Element accepted Yes ☐ No ☐	
3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?	The nursing staff will be in-serviced on the Standards of Practice of Medication Administration, MARs and reporting errors to the RN nurse manager/designee (Exhibit 1) on 3/7/24. Any nursing staff that were unable to attend will be in-serviced before their next shift. During daily (business days) stand up meetings the RN nurse manager or designee will review new orders for accuracy.
OSDH Response: Element accepted Yes ☐ No ☐	
4. How will the assisted living center monitor its performance to make sure corrections are sustained? Include: a. How the correction will be evaluated for effectiveness; b. How the correction will be incorporated into the center's quality assurance system; and c. How monitoring records will be kept to evidence the correction.	The RN nurse manager/designee will review 5 MARS each week for a period of 12 weeks to ensure that the MAR matches the Physician's order and that medication is being administered correctly. Results of the audits (Exhibit 2) will be communicated to the QAPI committee. Audits will be reviewed by the QAPI committee. The results of the audits will be reported to the QAPI committee for a period of 12 weeks, the threshold for compliance will be 100%. Evidence of the correction will be maintained in the quality assurance committee meeting minutes.
OSDH Response: Element accepted Yes ☐ No ☐	
5. On what date will corrective action be completed?	3/15/2024
OSDH Response: Element accepted Yes ☐ No ☐	

Administrator's Signature **Patricia Behrens**	**Date 3/7/2024**

OAC 310:663-25-4(F)

If this sheet amends or adds information to a Plan of Correction previously submitted, indicate the date of the addendum and by whom it is submitted.			
Addendum Date	Enter a date of addendum.	**Submitted by**	Enter name of person submitting addendum.
Items Below Are For OSDH Use Only			
Plan of Correction: ☐ Acceptable ☐ Unacceptable Date: Click here to enter a date. Surveyor: Surveyor			
If Plan of Correction is unacceptable, the reasons are as follows: Click here to enter text. Facility in Compliance by: Click here to enter a date.			

OKLAHOMA
State Department
of Health

Delivery via email to: PBehrens@covliving.org

April 24, 2024

License Number: AL7264

Ms. Patricia Behrens, Administrator
Covenant Living Of Bixby
7300 East 121st Place South
Bixby, OK 74008

RE: Survey Event ZD4B12

Dear Ms. Behrens:

On **April 23, 2024,** an off-site paper revisit was conducted for your facility by this agency. The findings of the revisit indicate that the deficiencies cited during your survey on **January 3, 2024,** have now been corrected effective **March 15, 2024.**

If you have any questions concerning the information in this letter, please contact the Enforcement worker at (405) 426-8200.

Respectfully,

Tempal Killman

Tempal Killman, Enforcement Analyst
Long Term Care | Enforcement Division
Oklahoma State Department of Health

Enclosure

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL7264	A. BUILDING: _____ B. WING _____	R-C 04/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COVENANT LIVING OF BIXBY	7300 EAST 121ST PLACE SOUTH BIXBY, OK 74008

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{C 000}	INITIAL COMMENTS On 04/23/24, an offsite/revisit was conducted. The deficiencies were cleared.	{C 000}		

Oklahoma State Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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C1923	Continued From page 8	C1923		
C1923 SS=D	310:663-19-2(a)(3) MEDICATION ADMINISTRATION (3) An accurate written record of medications administered shall be maintained. The medication record shall include: (A) The identity and signature of the person administering the medication. (B) The medication administered within one hour of the scheduled time. (C) Medications administered as the resident's condition may require (p.r.n.) are recorded immediately, including the date, time, dose, medication, and administration method. (D) Adverse reactions or results. (E) Injection sites. (F) An individual inventory record shall be maintained for each schedule II medication prescribed for a resident. (G) Medication error incident reports. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to accurately document the administration of medication for one (#6) of four sampled residents whose clinical records were reviewed for medication administration. The facility entrance conference worksheet documented 36 resident residing in the assisted living center. Findings: Resident #6 had diagnoses which included	C1923		

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C1923	Continued From page 9 chronic pain. The physician's order, dated 06/20/23, documented for the resident to receive 10 mg oxycodone with acetaminophen at 7:00 a.m. The June 2023 MAR documented the resident received 10 mg oxycodone with acetaminophen at 7:00 a.m. from 06/23/23 through 06/30/23. The July 2023 MAR documented the resident received 10 mg oxycodone with acetaminophen at 7:00 a.m. from 07/01/23 through 07/31/23. The July 2023 MAR documented the resident received an additional 10 mg oxycodone at 7:00 a.m. from 07/20/23 through 07/31/23. The August 2023 MAR documented the resident received 10 mg oxycodone with acetaminophen at 7:00 a.m. from 08/01/23 through 08/29/23. The August 2023 MAR documented the resident received an additional 10mg oxycodone at 7:00 a.m. from 08/01/23 through 08/29/23. The physician's order, dated 08/29/23, documented the resident was to receive 10mg oxycodone at 7:00 a.m. On 01/05/24 at 11:55 a.m., a summary list of medications delivered from the pharmacy for resident #6 was reviewed. The summary documented multiple deliveries of 10mg oxycodone with acetaminophen but the list failed to document 10mg oxycodone (without acetaminophen) was delivered to the facility. On 01/05/23 at 5:05 p.m., the DON stated they entered each order and checked them against	C1923		

INVESTIGATIVE REPORT

Facility: **Covenant Living of Bixby**
Address: **7300 East 121st Place South**
City, State, Zip: **Bixby, Ok., 74008**
Provider #: **AL7264**
Complaint #: **OK00061324**
Investigation Date(s): **01/02/24 through 01/05/24**

ALLEGATION(S)

The center failed to ensure medications were administered according to the physicians' orders.
The center failed to have and/or implement effective pharmacy policy and procedures to receive, dispense, and administer medications according to standards of practice.

An unannounced on-site investigation was initiated 01/02/2024 at 3:15 p.m.

A sample of nine residents, including any identified residents, was selected for the investigation based on the concerns relevant to the allegation(s).

The investigation was conducted following standards set by the statutes, rules and regulations of the State of Oklahoma utilizing Investigative Protocols. Evidence was obtained through observations; interviews with residents, family members, staff members and others as indicated; and review of pertinent written and electronic records.

A Summary of Complaint Investigation:

A medication pass was conducted with multiple staff members, working day and evening shift. The certified medication aides were observed to follow standards of practice. The medication room was observed to be of a comfortable temperature and in an orderly manner. Medications were stored correctly in the medication room and medication carts.

Interviews were conducted with residents, certified medication aides, the DON, and administrator.

The electronic medical records for the sampled residents were reviewed, including their medication administration records, clinical notes, monthly medication reviews by the registered nurse/pharmacist, and the quarterly pharmacist reviews. Pertinent pharmacy medication requisition reports were reviewed. The center's policy and procedures related to medication administration were reviewed.

The attached Statement of Deficiencies, Form 2567 will identify any deficiencies cited.

Thank you for bringing your concerns to our attention.

Oklahoma State Department of Health
Long Term Care Service

Date report completed: 01/11/2024

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C 000	INITIAL COMMENTS A relicensure survey was conducted from 01/02/24 through 01/05/24. A complaint investigation (#OK00061324) was conducted in conjunction with the survey. Listed below are abbreviations that will be used throughout this document. CMA - certified medication aide DON - director of nursing eMAR - electronic medication administration record EMR - electronic medical record LPN - licensed practical nurse MAR - medication administration record mg - milligram	C 000		
C 921 SS=F	310:663-9-2(a) MEDICATION STAFFING (a) Each assisted living center shall provide or arrange qualified staff to administer medications based on the needs of residents. Medications shall be reviewed monthly by a registered nurse or pharmacist and quarterly by a consultant pharmacist. This LEVEL B is not met as evidenced by: Based on record review and interview, the facility failed to: a. have a registered nurse or pharmacist perform the residents' monthly medication reviews for four (#1, 2, 3, and #6) of four residents whose clinical	C 921		

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C 921	Continued From page 1 records were reviewed for medication administration; and b. perform a quarterly medication review by a pharmacist for all residents in the facility. The facility entrance conference worksheet documented 36 resident residing in the assisted living center. Findings: 1. On 01/04/24 at 5:00 p.m., the monthly medication review for 2022 for Residents #1, 2, 3, and #6 were reviewed with the Director of Nursing. The clinical records documented a monthly medication review by a registered nurse or pharmacist on 02/25/22 and again on 11/28/22. There were no monthly medication reviews documented for March 2022 through October 2022. On 01/04/24 at 5:00 p.m., the director of nursing stated they were hired near the end of 2022 and did not know why the facility failed to complete the monthly medication reviews prior to their hire date. The monthly medication review for Resident #1, Resident #2, Resident #3, and Resident #6 were reviewed for 2023. There was no documentation of a monthly review by a registered nurse or pharmacist for May 2023, September 2023, October 2023, or November 2023. On 01/04/24 at 5:05 p.m., the director of nursing stated they entered each medication order into the electronic medical record and checked those orders against the eMAR, one medication at a time. The director of nursing stated checking	C 921		

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C 921	Continued From page 2 each order against the eMAR was taking more and more time. The director of nursing stated they had limited training in the use of the electronic medical record and did not know they could view a full month of a residents' MAR. 2. The pharmacist quarterly medication review, dated 10/11/23, read in part, "...due to a technical issue with [the EMR] I do not have access to the patients med charts at this time. They will be reviewed once we have access..." There was no further documentation a quarterly medication review of the residents' medications was performed by a pharmacist. On 01/04/23 at 5:15 p.m., the director of nursing stated they knew the pharmacist had difficulty accessing the residents' clinical records, but did not know the pharmacist had not returned to complete the quarterly review. On 01/04/23 at 5:20 p.m., the administrator stated they were not aware the pharmacist did not complete the quarterly review.	C 921		
C1912 SS=E	310:663-19-1(b) INCIDENTS REQUIRING REPORT (b) Each continuum of care facility and assisted living center shall prepare a written incident report for the following incidents: (1) allegations and incidents of resident abuse; (2) allegations and incidents of resident neglect; (3) allegations and incidents of misappropriation of resident's property; (4) accidental fires and fires not planned or supervised by facility staff, occurring on the licensed real estate; (5) storm damage resulting in relocation of a	C1912		

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C1912	Continued From page 3 resident from a currently assigned room; (6) deaths by unusual occurrence, including accidental deaths or deaths other than by natural causes; (7) residents missing from the assisted living center upon determination by the assisted living center that the resident is missing; (8) utility failure for more than 4 hours; (9) incidents occurring at the assisted living center, on the assisted living center grounds or during assisted living center sponsored events, that result in fractures, head injury or require treatment at a hospital; (10) reportable diseases and injuries as specified by the Department in OAC 310:515 (relating to communicable disease and injury reporting); and, (11) situations arising where a criminal act is suspected. Such situations shall also be reported to local law enforcement. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to prepare a written incident report for one (#9) of one resident with a documented allegation of abuse, an allegation of neglect for one (#4), and allegations of neglect for an unknown number of residents.	C1912		

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C1912	Continued From page 4 The facility entrance conference worksheet documented 36 resident residing in the assisted living center. Findings: A disclosed email, dated 11/26/23, documented Resident #9 was terrified to the point of crying. The email stated the resident complained the named employee had been very ugly to them since their daughter talked to the facility about the argument between Resident #9 and the named employee. The email stated Resident #9 was truly scared in anticipation of the named employee working the next day. The email, dated 11/26/23, documented a family member for Resident #4 found pills in a cup in the resident's jacket. The email, dated 11/26/23, also documented there were several complaints from an unknown number of residents that a named agency aide was rude, dismissive, and did not give all of the medications due to the unknown number of residents who complained despite the residents bringing the missing medications to the attention of the agency aide. On 01/05/23 at 2:40 p.m., the DON stated Resident #9 had dementia and when they had spoke with resident #9, the resident was fine with the named employee. The DON stated the weekend staff spoke with the family member and the DON had reviewed the charts and MARs documented all residents received all their medications. The DON stated they spoke with several residents but none were able to state which medications they missed	C1912		

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C1912	Continued From page 5 during the agency employee's shift. The DON stated they had placed the agency employee on the do not return list. The DON stated they did not write an incident report or notify the State Agency of the above allegations because their investigations determined the allegations were unfounded. The DON stated they did not document the investigations related to the above allegations. On 01/05/23 at 2:50 p.m., the administrator stated they were to be contacted with any allegations of abuse or neglect. The administrator stated they were not aware of the allegation of abuse nor the allegations of neglect documented in the email. The administrator stated all the staff were trained in the prevention of abuse and neglect and should know to report any allegation immediately. The administrator stated there was no incident report or state reportable incident related to the allegations documented in the email. On 01/05/23 at 5:48 p.m., LPN #1 stated they spoke with Resident #9 the day of the allegation and the resident stated the named employee gave off an attitude when they provided the resident's care which gave the resident an uncomfortable feeling that the named employee did not want to be there providing care to the resident. The LPN stated there was nothing physical about the allegation of abuse. The LPN stated after they visited with the resident, they notified their superior of the allegation via an email they sent at the end of their weekend shift. The LPN stated they did not document any of the allegations in the residents' clinical records nor did they document their investigations of the	C1912		

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C1912	Continued From page 6 allegations. The LPN stated the only documentation of the allegations was in the email sent to their supervisor. The LPN stated they did not send the named employee home while they investigated the allegation and the agency employee left as the LPN arrived. The LPN stated they performed only a cursory investigation and notified their superior by email so whoever was responsible could perform a more thorough investigation during the week. The LPN stated they did not know who was responsible for notifying the State Agency of the allegations, nor the time frame to notify the State Agency, nor who in the facility was responsible for the investigation of allegations of abuse and neglect.	C1912		
C1921 SS=E	310:663-19-2(a)(1) MEDICATION ADMINISTRATION (1) Medications shall be administered only on a physician's order This Rule is not met as evidenced by: Based on record review and interview, the facility failed to administer medications according to physician's orders for one (#2) of four sampled residents whose clinical records were reviewed for medication administration. The facility entrance conference worksheet documented 36 resident residing in the assisted living center. Findings:	C1921		

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C1921	Continued From page 7 Resident #2 had diagnoses which included GERD and a respiratory infection. A physician's order, dated 01/30/23, documented the resident was to receive omeprazole 20 mg twice daily. A physician's order, dated 03/07/23, documented the resident was to receive omeprazole 20 mg once daily. The March 2023 through April 2023 MARs documented omeprazole was administered twice daily from 03/01/23 through 04/30/23. A physician's order, dated 10/23/23, documented the resident was to receive 20 mg prednisone, two tabs (40 mg total) once daily for three days. The October 2023 MAR documented the resident received prednisone 40mg once daily from 10/23/23 through 10/27/23, for a total of five days. On 01/04/23 at 5:07 p.m., the DON stated the residents were able to make their own arrangements to and from their physician's visits and it was often difficult to get updated orders from the residents' physicians. The DON stated they were not aware the prednisone was documented as given for five days. The DON stated they did not know why the MAR documented nine consecutive days available to administer for a medication that was to be given for only three days. The DON stated there was no way to determine if this was a medication administration error or a documentation error.	C1921		

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C1923	Continued From page 8	C1923		
C1923 SS=D	310:663-19-2(a)(3) MEDICATION ADMINISTRATION (3) An accurate written record of medications administered shall be maintained. The medication record shall include: (A) The identity and signature of the person administering the medication. (B) The medication administered within one hour of the scheduled time. (C) Medications administered as the resident's condition may require (p.r.n.) are recorded immediately, including the date, time, dose, medication, and administration method. (D) Adverse reactions or results. (E) Injection sites. (F) An individual inventory record shall be maintained for each schedule II medication prescribed for a resident. (G) Medication error incident reports. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to accurately document the administration of medication for one (#6) of four sampled residents whose clinical records were reviewed for medication administration. The facility entrance conference worksheet documented 36 resident residing in the assisted living center. Findings: Resident #6 had diagnoses which included	C1923		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C1923	Continued From page 9 chronic pain. The physician's order, dated 06/20/23, documented for the resident to receive 10 mg oxycodone with acetaminophen at 7:00 a.m. The June 2023 MAR documented the resident received 10 mg oxycodone with acetaminophen at 7:00 a.m. from 06/23/23 through 06/30/23. The July 2023 MAR documented the resident received 10 mg oxycodone with acetaminophen at 7:00 a.m. from 07/01/23 through 07/31/23. The July 2023 MAR documented the resident received an additional 10 mg oxycodone at 7:00 a.m. from 07/20/23 through 07/31/23. The August 2023 MAR documented the resident received 10 mg oxycodone with acetaminophen at 7:00 a.m. from 08/01/23 through 08/29/23. The August 2023 MAR documented the resident received an additional 10mg oxycodone at 7:00 a.m. from 08/01/23 through 08/29/23. The physician's order, dated 08/29/23, documented the resident was to receive 10mg oxycodone at 7:00 a.m. On 01/05/24 at 11:55 a.m., a summary list of medications delivered from the pharmacy for resident #6 was reviewed. The summary documented multiple deliveries of 10mg oxycodone with acetaminophen but the list failed to document 10mg oxycodone (without acetaminophen) was delivered to the facility. On 01/05/23 at 5:05 p.m., the DON stated they entered each order and checked them against	C1923		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL7264	A. BUILDING: _____ B. WING _____	C 01/03/2024

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C1923	Continued From page 10 the eMAR, which the CMA used to administer the medications. The DON stated they did not notice the duplicate medication on the eMAR. The DON stated they felt it was a documentation error because the CMA would notice the duplicate order not give the medication twice. The DON stated the CMA was to notify them of any issue with the residents' medications or their MAR. The DON stated they had determined there was a problem with ordering medications in a timely manner and assigned CMAs to monitor the medications weekly and report back to the DON any concerns related to medication administration. The DON stated they provided a worksheet of assignments to the CMAs but the DON did not always receive the worksheets back to review.	C1923		